

**FOR REINSTATEMENT OF EXPIRED LICENSE  
OR REACTIVATION OF INACTIVE STATUS**

**FOR LICENSED PRACTICAL NURSE OR REGISTERED NURSE  
IN THE DISTRICT OF COLUMBIA**

Thank you for your interest in Reinstating/Reactivating your District of Columbia nursing license. We look forward to providing expedient and professional service. However, the efficiency of our service is dependent upon the care with which you've completed your application. This package contains the application and instructions for Reinstatement of an expired license or Reactivation of an inactive license. Please read the instructions carefully.

**Reinstatement of an expired nursing license or  
Reactivation of an inactive license**

Follow the instructions provided below and complete all sections of the application. If you require more space to provide explanations for screening questions, attach typed responses to the application.

**PLEASE NOTE: Licenses expire June 30<sup>th</sup> – Odd year for LPNs – Even year for RNs.**

**REINSTATEMENT OF EXPIRED LICENSE**

**REINSTATEMENT OF LICENSE EXPIRED LESS THAN ONE (1) YEAR**

If the LPN/RN fails for any reason to renew their license, the Board shall reinstate the license if the health professional:

1. Submits application to the Board for reinstatement of the license
2. Pays reinstatement fee
3. Submits evidence of having met the Board's \*continuing education requirement (LPN-18, RN-24).

**REINSTATEMENT OF LICENSE EXPIRED MORE THAN ONE (1) YEAR BUT LESS THAN FIVE (5) YEARS**

If the LPN/RN fails for any reason to renew their license, the Board shall reinstate the license if the health professional:

1. Submits application to the Board for reinstatement of the license
2. Pays reinstatement fee
3. Submits a verification of licensure status, if currently licensed in another jurisdiction

**NURSYS:** If your licensure status can be verified through NURSYS please complete verification on-line at [www.nursys.com](http://www.nursys.com). **Attach a copy of your NURSYS receipt to this application. Verification by mail:** Submit your verification along with your application in a sealed envelope OR ask verifying board to send your licensure verification to the address provided in this packet.

**Please note: A copy of your license may not be used to verify your licensure status.**

**REINSTATEMENT OF LICENSE EXPIRED MORE THAN FIVE (5) YEARS: Not currently licensed in another jurisdiction**

If the LPN/RN fails for any reason to apply for reinstatement of their license for more than five (5) years after the license expires, the LPN/ RN may become licensed by meeting the requirements in existence at the time of initial

licensure:

1. Submits application to the Board for reinstatement of the license
2. Pays reinstatement fee
3. Submits evidence of having completed a nurse refresher course.

## REACTIVATION TO ACTIVE STATUS

A registered nurse or licensed practical nurse on paid inactive status may reactivate their licensure status by:

1. Submitting application to the Board for reactivation of licensure
2. Paying fee to reactivate licensure status
3. Submitting evidence of having met the board's \*continuing education requirement (LPN-18, RN-24)
4. APRNs only: Request certifying body to send verification of current certification directly to the Board

## THE APPLICATION PROCESS

Upon submission of the required application documents, the District of Columbia Board of Nursing will review your application and upon final approval, issue you a license to practice in the District of Columbia.

If you submit an application that is incomplete or otherwise deficient, Health Regulation Licensing Administration's (HRLA) processing staff will notify you of the deficiencies. If the Board has questions or concerns, you will also be notified.

## WHERE TO FILE

Documents should be sent to the following address:

Board of Nursing  
P. O. Box 37802  
Washington, D.C. 20013

If you have any questions, call HRLA's Customer Service toll free line at 1-877-672-2174 between 8:30 a.m. and 4:30 p.m. EST Monday through Friday. Please read these instructions carefully to facilitate prompt processing of your application. Illegible applications and applications submitted without required signatures or with incorrect fees will be returned in their entirety, including fees. Please print or type all information except signatures.

## GENERAL REQUIREMENTS FOR ALL APPLICANTS

All applicants for a nursing license in the District of Columbia shall meet the following requirements:

- a. Must be at least 18 years of age; and
- b. Must not have been convicted of a crime of moral turpitude which bears directly on the applicant's fitness to be licensed; and

All applicants must submit the following in order to be considered for licensure:

- a. A complete and signed application, including required supporting documents; and
- b. Two passport-type photos of the applicant's face, measuring approximately 2" x 2" with the applicant's name printed on the back. Home snapshots are not acceptable.

## ADDITIONAL INFORMATION

Change of address notification:

You should know that you are required by regulation to report all changes of your business or residence address to the Board within 30 days, failure to do so is punishable by a \$100 fine for first offense and higher for subsequent offenses. HRLA will update the address change in your database record. Requests for address change

should be made via fax to 202-724-5145 or letter sent to HRLA at the address in the middle of this page. Without an updated mailing address, you may not receive your renewal notice.

## COMPLETING THE LICENSE APPLICATION

### Section 1. Licensee Information

Please read this section carefully. Enter your name, address, SSN and other requested information. If updated check the box provided. If your last active license was issued in another name, you must provide (with this application) a copy of a legal name change document. Acceptable documents include a marriage certificate, divorce decree, court order or spouse's death certificate. Please enter previous name and date of change in Section 3 of the application.

### Section 1A. Business Address

Please provide the requested information if available.

### Section 2. License Reinstatement/Reactivation Fees

- a. There are two license types from which to choose:  
LPN – Licensed Practical Nurse  
RN – Registered Nurse
- b. You may pay the application and license fee by a single check or money order. It is recommended that you pay by check, so that you have ready proof of payment. Checks or money orders should be made payable to DC Treasurer and submitted with your application packet. Do **NOT** send cash. Please print your name on your check, if it is not pre-printed.

### Section 3. Name Change

As mentioned in Section 1 above, if your last active license was issued in another name, please provide that name and date of name change in this section.

### Section 4. Other Changes

Include any changes not covered in Sections 1 or 1A of the application.

### Section 5. Special Instructions - Please Read:

#### CRIMINAL BACKGROUND CHECK

To schedule your CBC (Live Scan/Fingerprinting) with MorphoTrust access <http://www.LIENROLLMENT.COM/state/?st=DC> or call 1-877-783-4187

#### \*CONTINUING EDUCATION REQUIREMENTS

RNs: 24 Contact Hours

APRNs: 24 Contact Hours (Must include a minimum of 15 contact hours in a continuing education program that includes a pharmacology component)

LPNs: 18 Contact Hours

**ANY OF THE FOLLOWING METHODS OF COMPLIANCE MAY BE UTILIZED**

### **CONTACT HOUR OPTION**

May be used if you have completed a continuing education offering

#### **DOCUMENTATION NEEDED**

An original verification form from accredited continuing education provider

### **ACADEMIC OPTION**

May be used when you have completed a course leading towards a degree in nursing or any academic course relevant to the practice of nursing

#### **DOCUMENTATION NEEDED (any one of the following):**

Attach a copy of your transcript OR End of the Semester report.

### **TEACHING OPTION**

May be used if you have developed and taught a course or educational offering approved by board approved accrediting body. Four (4) Contact Hours for each approved contact hour. *[Please note: This is not an option for nurses required to develop and teach continuing education courses as a condition of employment].*

#### **DOCUMENTATION NEEDED (any of the following):**

Verification form indicating your name, the name of the accrediting body and the number of contact hours OR Letter from an accrediting body acknowledging their approval of your course.

### **AUTHOR OR EDITOR OPTION**

Author of a book chapter or peer reviewed article (if the manuscript has been published or accepted for publication during the period for which credit is claimed) or editor of a book during the renewal period. Twenty-four (24) Contact Hours Awarded

#### **DOCUMENTATION NEEDED (any one of the following):**

Letter of acceptance OR Copy of title page of book or article (for articles, include name of journal, if not indicated on the title page) OR Copy of page listing you as editor.

### **Section 6. Screening Questions:**

If you answer "yes" to questions A through G, please provide a complete explanation on a separate sheet of paper. If more space is required to fully answer questions, attach additional sheets with typed responses. False or misleading statements will be cause for disciplinary action and could be cause for criminal prosecution pursuant to DC Code 22-2514.

***PLEASE NOTE: If you have been convicted of a crime or have had actions taken against your license, please provide official documentation which details the outcome or current status of the case.***

### **Section 7. Licensee Affidavit**

By signing the application you are attesting under penalty of perjury that all information and attached documents are true to the best of your knowledge.

**LICENSE REINSTATEMENT APPLICATION  
 REACTIVATION OF INACTIVE STATUS APPLICATION**

Please read instructions at the beginning of each section as you complete this form. See Section 5 for special instructions specific to your license. If you have any questions, call HRLA's Customer Service line Monday through Friday, 8:30AM to 4:30PM EST at 1-877-672-2174.  
**A Charge of \$65.00 will be imposed for dishonored checks (Public Law 89-208)**

**SECTION 1. LICENSEE INFORMATION - Please provide the information requested below. If updated, check box provided at right and enter data in Section 3 or 4 on the next page. If this is a changed name, you must provide legal documentation for the name change. Acceptable documentation for individuals includes a copy of a marriage certificate, divorce decree, or court order.**



Keep a copy of this renewal form and your payment for your records. Remember that you are required by law to notify the Board of any address change within thirty (30) days of the change.

PLEASE PRINT Name change due to:  Marriage  Divorce  Court Order

Full Name: \_\_\_\_\_ License Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ \*SSN/FEIN: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_ Birth date: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

\*Pursuant to D.C. Official Code Section 3-1205.5 (b) (2001) (Health Occupations Revision Act), **applicants are required to provide a Social Security Number (SSN)** on applications for a professional license. Please provide your Social Security Number above.

**SECTION 1A. BUSINESS ADDRESS**

Please note: This information will be made available to the public.

Company Name: \_\_\_\_\_  Apartment  Suite  Floor  PO Box Number \_\_\_\_\_

Business Street Address: \_\_\_\_\_ City/State/Zip Code: \_\_\_\_\_

Business Phone Number \_\_\_\_\_ Business Fax Number \_\_\_\_\_ Business E-Mail Address \_\_\_\_\_

**SECTION 2. LICENSE REINSTATEMENT/REACTIVATION FEES – Select the type of action you wish to take for your license.**

Please check the appropriate box(es).

- |   | <u>FEE</u>      |
|---|-----------------|
| A. <input type="checkbox"/> RN/LPN  | <u>\$230.00</u> |
| B. <input type="checkbox"/> APRN License and authority  | <u>\$348.00</u> |
| C. <input type="checkbox"/> APRN authority (only), RN license must be active                    | <u>\$230.00</u> |
| D. <input type="checkbox"/> CBC (Payment made when you register with <b>MorphoTrust</b> online) |                 |
| E. <input type="checkbox"/> CBC (Previously completed for DC Health Professional License)       | <u>\$0.00</u>   |
| F. <input type="checkbox"/> Reactivate (Paid Inactive License)                                  | <u>\$34.00</u>  |

Make check/money order payable to:  
**DC Treasurer** and mail along with this application to:

Department of Health  
 Health Regulation Licensing Administration  
 Board of Nursing  
 P.O. Box 37802  
 Washington, D.C. 20013  
 Phone: 202/724-8000  
[www.doh.dc.gov](http://www.doh.dc.gov)

**Licenses expire June 30<sup>th</sup> Odd year for LPNs – Even year for RNs**

**SECTION 3. NAME CHANGE (Prior Name) Refer to Section 1. Licensee Information on Previous Page**

In the space below please provide name(s) from your most recent Active license.

Name(s): \_\_\_\_\_  
 Last First Middle Date of Change

**SECTION 4. OTHER CHANGES, IF NECESSARY (Please specify change(s) and enter on lines provided below)**

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**SECTION 5. SPECIAL INSTRUCTIONS**

**CRIMINAL BACKGROUND CHECK (NEW REQUIREMENT):**

“L-1 Enrollment Services”

L-1 Enrollment: Visit [www.L1ENROLLMENT.com](http://www.L1ENROLLMENT.com) or Call 1-877-783-4187

**IF YOU HAVE COMPLETED A CBC FOR THE PURPOSE OF LICENSURE WITH DC HRLA  
 YOU ARE NOT REREQUIRED TO COMPLETE ANOTHER CBC.**

**IF WE RECEIVE EVIDENCE OF AN ARREST OR CONVICTION, YOU WILL BE ASKED TO PROVIDE COURT PAPERS.**

**REINSTATEMENT OF LICENSE EXPIRED LESS THAN A YEAR/REACTIVATION OF LICENSE EXPIRED LESS THAN FIVE (5) YEARS.**

You must:

- Attach proof of having met the CE requirements. Contact Hours: APRNs: 24; RNs: 24; LPNs: 18. For CE Options go to [www.hrla.doh.dc.gov](http://www.hrla.doh.dc.gov) (Nursing Applications Instructions) or [www.cebroker.com](http://www.cebroker.com)

**REINSTATEMENT OF LICENSE EXPIRED MORE THAN ONE (1) YEAR BUT LESS THAN FIVE (5) YEARS FOR APPLICANTS LICENSED IN ANOTHER STATE/JURISDICTION.**

You must:

- Provide verification of current and active licensure by asking your state/jurisdiction of licensure to submit a verification of your licensure status directly to the D.C. Board of Nursing OR if you are licensed in a state that is a member of Nursys verification system go to [www.nursys.com](http://www.nursys.com) to apply for verification of your license.
- Attach proof of having met the CE requirements. Contact Hours: APRNs: 24; RNs: 24; LPNs: 18. For CE Options go to [www.hrla.doh.dc.gov](http://www.hrla.doh.dc.gov) (Nursing Application Instructions) or [www.cebroker.com](http://www.cebroker.com)

**REINSTATEMENT OF LICENSE EXPIRED MORE THAN FIVE (5) YEARS FOR APPLICANTS WHO DON'T HAVE AN ACTIVE LICENSE IN ANOTHER STATE/JURISDICTION.**

You must:

Submit evidence of having completed a nursing refresher course.

**APRNs** must also attach a copy of current APRN certification. You can apply to renew your DC Controlled Substances Registration (CSR) after you reinstate your APRN license. Visit <http://doh.dc.gov/node/155142> to download a copy of the CSR application. The fee is \$130 and if your current registration is EXPIRED - an additional fee of \$35 (\$165 total) is required. Make all checks and money orders payable to DC TREASURER. Contact the Pharmaceutical Control Division via e-mail at [Abena.Osae-Addo@dc.gov](mailto:Abena.Osae-Addo@dc.gov) if you have any questions.

**Be sure to keep a copy of this reinstatement form and your payment for your records.**

**Remember that you are required by law to notify your professional board of any address change within thirty (30) days of the change.** You may send address change to our physical address: Department of Health, Health Regulation & Licensing Administration, First Floor Processing Center, 899 North Capitol Street, NE, Washington, D.C. 20002 or email to [hrla.doh@dc.gov](mailto:hrla.doh@dc.gov). This will help ensure that you receive your next renewal notice in a timely manner.

**SECTION 6. QUESTIONS – Applicants MUST answer all of the following questions.**

Please answer questions A through H by placing an “X” in the appropriate boxes. If you answer “Yes” to questions A through G below, you must provide full information and complete details on a separate sheet of paper, including copies of relevant court documents, and attach to this form.

**A. Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement.**

Please read the information below carefully before responding to this yes or no question, as **any false information provided requires that the Department of Health proceed immediately to revoke your License** for which you are now applying, and fine you one thousand dollars (\$1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER “YES” TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR REINSTATEMENT APPLICATION BE DENIED.

**Have you failed to file your District tax returns pursuant to D.C. Official Code § 47-2862(a) (FY 2007 Budget Support Act of 2006**

Yes No

**As of this date, do you owe more than one hundred dollars (\$100.00) to the District of Columbia Government as a result of any of the following?**

1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);
2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
4. Past due taxes;
5. Past due District of Columbia Water and Sewer Authority service fees; or
6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)?

Yes No

The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the *Clean Receiving a License or Permit Act of 1996*, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).

B	Since you were last licensed in DC, have you been convicted or arrested for a crime (other than minor traffic violations) not last reported to the Board?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
C	Since your last renewal: (1) Have you withdrawn an application for licensure/certification/registration to practice your profession in any jurisdiction? (2) Has any authority or peer review board taken adverse action against your license or privileges? (3) Have you been or are you currently being investigated by any authority or peer review board for any violation of state, federal, or local law? (4) Has any authority or peer review board informed you of any pending charge(s) or investigation not previously reported to this Board?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
D	Do you have a physical or mental condition that currently impairs your ability to practice your profession?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
E	Since you were last licensed in DC, have you been diagnosed or treated for substance abuse?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
F	Since you were last licensed in DC, have you been involved in a malpractice suit? If yes, provide date of incident, allegation, and disposition of case?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
G	Since you were last licensed in DC, have you ever been terminated or asked to resign from employment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
H	Once your license is reinstated, do you plan to practice Nursing in the District of Columbia?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**SECTION 7. LICENSEE AFFIDAVIT**

*I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.*

\_\_\_\_\_  
**LICENSEE SIGNATURE**

\_\_\_\_\_  
**LICENSEE NAME (Please print)**

\_\_\_\_\_  
**DATE**